

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER NORRIS HEALTH AND REHABILITATION CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	<p>1200-8-6 No Deficiencies</p> <p>During the Licensure survey conducted on February 10-12, 2014, at Norris Health and Rehabilitation Center, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.</p>	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE